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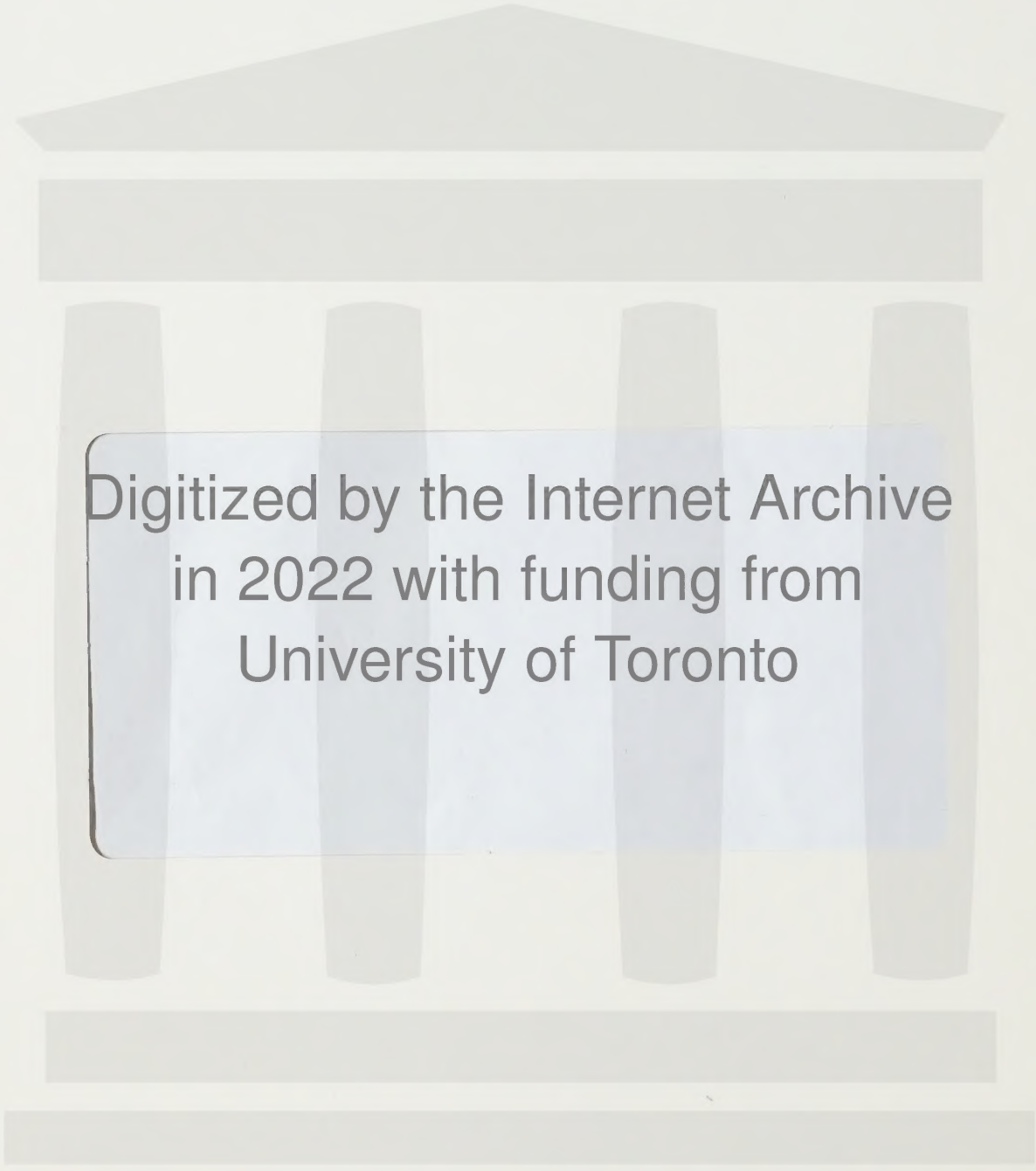
An Intervention Program for Women
Who Were Sexually Victimized in
Childhood or Adolescence

FINAL REPORT

Derek Jehu



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As requested by the National Department of Health and Welfare this report is written in conjunction with a manual for therapists who may wish to draw upon the findings of the University of Manitoba (U. of M.) program for their own practice. All the empirical data and clinical procedures that may be useful for this purpose are described in the manual (see overview below) rather than this report, and as the length of the manual may limit its free distribution the following book has been written and is currently being typed:

Jehu, D. Therapy with women who were sexually abused in childhood. (in association with Marjorie Gazan and Carole Klassen)

Problem and Objectives

The evidence reviewed in Appendix A indicates that the sexual abuse of children has been shown to be a not uncommon occurrence in several countries including Canada, and an unknown proportion of child victims experience psychosocial problems in adulthood that appear to be related to their previous abuse and its surrounding circumstances (Appendix B).

When the proposal for the U. of M. program was submitted to National Department of Health and Welfare there was very little information available on the prevalence and nature of these psychosocial problems among women seeking therapy, and one objective of the program was to begin to fill this gap in

knowledge. Similarly, there had been only very sparse and sporadic reports of interventions for these problems in the literature, consequently another objective of the U. of M. program was the sustained and comprehensive development of a treatment package with adequate evaluation of its effectiveness. Thus, the specific objectives of the project were stated in the proposal as follows:

"1. To alleviate the emotional, interpersonal, and sexual problems associated with childhood sexual victimization in a series of adult women who have sought treatment for these problems.

2. To increase knowledge of the nature of such problems among victims.

3. To further develop and refine an intervention package for use with this client group.

4. To evaluate the effectiveness of the package when used with this group."

Service Setting

The program was conducted in the Psychological Service Center at the University of Manitoba, which was established in 1969 as a training facility for Bachelor's and Master's students in social work, and doctoral students in clinical psychology. Approximately 400 clients from the community are treated in the center each year.

Duration of Project

The clinical work in the project was undertaken over a three year period from 1 October, 1983, to 30 September, 1986, and the final report and treatment manual were to be submitted by 31 March, 1987.

Project Staff

The grant holder and principal investigator was Professor Derek Jehu F.B.Ps.S., Ms. Marjorie Gazan R.P.N., B.A., M.S.W., and Ms. Carole Klassen M.S.W. were employed as research therapists, and Ms. Jane McCallum B.A. was the secretary to the project. Additionally, the following M.S.W. students participated in the clinical work of the project as part of their graduate training: Ann Doige, Reid Hartry, Rosemary Popescul, Gisele Rouillard, and David Schwab.

Publications

At the time of writing the following preliminary articles and chapters based on the project have been published:

Jehu, D., Gazan, M., & Klassen, C. (1984/5). Common therapeutic targets among women who were sexually abused in childhood. Journal of Social Work and Human Sexuality, 3, 25-45.

Jehu, D., Klassen, C., & Gazan, M. (1985/6). Cognitive

restructuring of distorted beliefs associated with childhood sexual abuse. Journal of Social Work and Human Sexuality, 4, 49-69.

Jehu, D., Gazan, M., & Klassen, C. (1985). Common therapeutic targets among women who were sexually abused in childhood. In M. Valentich & J. Gripton (Eds.) Feminist perspectives on social work and human sexuality. New York: Haworth.

Jehu, D., Klassen, C., & Gazan, M. (1986). Cognitive restructuring of distorted beliefs associated with childhood sexual abuse. In J. Gripton & M. Valentich (Eds.) Social work practice in sexual problems. New York: Haworth.

Now that the project is completed the book mentioned above has been written and several other articles are in preparation to report the results.

Presentations and Workshops

Those given to date are shown in Appendix C, and among those planned are papers to the European Conference on Child Abuse and Neglect in Rhodes, Greece, in April, 1987, and to the Third National Conference on Family Violence Research in Durhan, N.H., in July, 1987.

Overview of Treatment Manual

The contents of the 11 parts of this manual are summarized below.

Part 1. Description of Clients

Fifty one victims and 21 partners were treated in the program, and 10 of these victims terminated therapy prematurely for the reasons given in this part of the manual. The sources from which the victims were referred and the selection criteria for the project are described, together with data on the victims' demographic characteristics, families of origin, sexual abuse experiences, presenting problems, and previous treatment. This information is illustrated by case vignettes on nine of the victims.

The demographic characteristics reported are (a) age at commencement of treatment in the U. of M. program, (b) marital status, (c) educational level, (d) occupational group, (e) ethnicity, and (f) religion.

The families of origin are described in terms of (a) the relationships between parental figures, (b) the role and characteristics of father figures, (c) the role and characteristics of mother figures, and (d) the effectiveness of the parenting provided.

Data is presented on (a) the chronology of the sexual abuse experiences, (b) the sexual acts involved, (c) the relationship of the offender to the victim, (d) her reactions to the abuse, and (e) the circumstances of secrecy or

disclosure that accompanied it.

Prevalence rates for the presenting problems are reported in the general categories of (a) mood disturbances, (b) interpersonal problems, (c) sexual dysfunctions, and (d) stress disorders.

Part 2. Principles of Assessment, Treatment, and Evaluation

The principles of assessment that were applied in the U. of M. program are described in the stages of (a) preliminary interviews, (b) initial assessment interviews, (c) negotiating treatment objectives, and (d) the assessment and formulation of target problems, including the use of interviews, questionnaires, and client self-monitoring in multiple method and multiple informant assessment schemes.

The components of treatment are conceptualized in terms of general therapeutic conditions and more specific procedures, the latter being discussed in parts 3 to 10 of the manual. The general therapeutic conditions reviewed in this part are (a) the therapeutic relationship, (b) prognostic expectancy, (c) exploration and disclosure, (d) acceptance and support, (e) empathic understanding, (f) causal explanation, (g) repeated exposure, (b) therapist influence, (i) replication, (j) instigation, and (h) networking. Next, the process of treatment is described in the stages of (a) planning treatment, including decisions concerning the therapist(s), the client(s), the timing, and the procedures, (b) implementing treatment,

including resistances that are likely to be encountered, and (c) the termination of treatment.

The purposes of evaluation are stated as (a) providing feedback to clients, (b) indicating any necessity for revision of treatment, and (c) demonstrating the effectiveness of the intervention. The objectives of treatment are specified in terms of actual events. An appropriate selection of the assessment methods mentioned above is administered at suitable intervals throughout the assessment, treatment, and follow up periods. The results of these repeated measurements are reported and analyzed in case studies, time-series designs, and the one group pretest-posttest design. These results are evaluated according to the criteria of (a) the importance - or clinical significance - of any improvements, (b) the proportion of clients who improve, (c) the breadth of the therapeutic changes, (d) the durability of improvements, and (e) client satisfaction. Because of the lack of systematically evaluated interventions with previously sexually abused women a treatment package strategy was adopted in the U. of M. program.

Part 3. Mood Disturbances

Very high prevalence rates for low self esteem, feelings of guilt, and depressive episodes are reported for victims. It is hypothesized that one important source of these mood disturbances is certain distorted beliefs associated with their sexual abuse that are held by many victims.

The assessment procedures used for mood disturbances are (a) interviews, (b) instant replay, (c) remote recall, (d) roleplay, (e) induced imagery, (f) confrontation, (g) recording by victim, (h) Belief Inventory, (i) Beck Depression Inventory, (j) Battle Self Esteem Inventory, and (k) Hudson Index of Self Esteem.

Cognitive restructuring is employed to correct the victim's distorted beliefs and to alleviate their mood disturbances. This procedure involves (a) explaining its rationale to clients, (b) identifying the victim's beliefs, (c) recognizing any distortions in them, and (d) exploring more accurate alternative beliefs.

Victims commonly believe that they were responsible for their own abuse because (a) they complied with the offender's demands, (b) they kept the abuse secret, (c) they were seductive, (d) they asked questions about sexual matters, (e) they experienced physical pleasure during the abuse, (f) it gave them emotional pleasure, or (g) they gained material benefits. Alternatives to these self-blaming beliefs are explored and the inability of a child to give an informed consent is noted.

Other self-blaming beliefs commonly held by victims involve the exoneration of the offender because (a) he was providing sex education, (b) he did it for the child's gratification, or (c) to enhance their relationship, (d) he was

sexually frustrated, or (e) under the influence of alcohol, or (f) "sick". Alternatives to these beliefs are explored and a more balanced explanation of why men abuse children is described.

Many victims hold beliefs of a self-denigratory nature including that they are (a) worthless and bad, (b) different from other people, (c) stigmatized by others, (d) inadequate and inferior, and (e) subordinate to others in respect of personal rights. Victims may be especially prone to such beliefs because they hold certain dysfunctional attitudes that involve basing their self esteem (a) on the approval of others, (b) on being loved by someone else, or (c) on their accomplishments. The correction of these distorted beliefs and dysfunctional attitudes is discussed.

The problems and assessment and treatment procedures reviewed in this part of the manual are illustrated in two case reports, and the outcome of treatment for a series of 36 victims is described in terms of (a) the chronology of the intervention (b) the clinically and statistically significant improvements in distorted beliefs, (c) the clinically and statistically significant improvements in mood disturbances, (d) the beneficial side effects on marital relationships and sexual functioning, and (e) the victims' very positive evaluation of the treatment they received.

Part 4. Interpersonal Problems

The common themes of isolation, insecurity, discord, and inadequacy are identified in the interpersonal relations of victims. More specifically, their relations with men are characterized by insecurity, anger, subordination of the victim, promiscuity and oversexualization. Additionally, victims may be especially vulnerable to rape in adulthood and to involvement in prostitution. Discord is prevalent in the marital relationships of victims, and their partners are often exploitive and overdependent. Some victims are disparaging and angry towards other women. The parenting capacities of most victims are very satisfactory but a proportion are inadequate in this respect, in some cases extending to physical abuse. Finally, the relations of many victims with their families of origin are characterized by (a) exploitation and scapegoating of the victim, (b) anger and grief reactions on her part, and (c) her loyalty towards and idealization of the family.

The procedures used to assess interpersonal problems are (a) interviews, (b) Belief Inventory, (c) Hudson Index of Self Esteem, (d) Assertion Inventory, (e) Fear Survey, (f) Dyadic Adjustment Scale, (g) Marital Relationship Questionnaire, (h) reconstructive techniques, (i) confrontation, (j) recording by victim and partner, and (k) Target Complaint Scales.

Among the general therapeutic conditions discussed in Part 2 the following are especially important in the treatment of interpersonal problems (a) acceptance and support, (b) empathic

understanding, (c) replication, (d) instigation, and (e) networking. More specific procedures used in this treatment include (a) cognitive restructuring, (b) assertiveness training, (c) stress management, (d) communication training, (e) problem solving, and (f) anger control.

The interpersonal problems and assessment and treatment procedures discussed in this part of the manual are illustrated by 15 case examples.

Part 5. Assertiveness Training Group

Many victims tend to be passive and subservient individuals who lack assertive skills. With the aim of promoting these skills an assertiveness training group was provided for five victims who were also receiving individual or couple therapy in the U. of M. program. The group met for 10 sessions with a male and a female therapist.

The procedures used to assess assertiveness are (a) interviews, (b) Target Complaint Scales, (c) Assertion Inventory, (d) Hudson Index of Self Esteem, and (e) a client satisfaction questionnaire.

The treatment procedures involve (a) modeling, (b) behavioral rehearsal, (c) cognitive restructuring, (d) structured exercises, (e) didactical and printed materials, and (f) homework assignments.

The group appeared to facilitate assertive responses among the participants and to increase their understanding and

acceptance of their own personal rights, although they still tended to experience some discomfort when behaving assertively. Their evaluation of the group program was generally positive.

Part 6. Situation/Transition Group for Partners

In the section on partners in the recommendations for further research below a range of problems experienced by these individuals is summarized. With the aims of clarifying and alleviating some of these difficulties a group was instituted for eight partners who were also receiving couple therapy with their victim spouses in the U. of M. program. The group met for 15 sessions with a male and a female therapist.

The intervention was conceptualized and conducted as a situation/transition group which addressed issues including the partners' (a) feelings of having been victimized vicariously, (b) sense of deprivation, confusion, and loss of control in their marriage, including its sexual and communication aspects, (c) anger toward the offenders, and (d) negative self concept and mood of depression. The evaluation of the group by the participants was generally positive.

Part 7. Sexual Dysfunctions

Almost all the victims in the U. of M. program reported at least one of the following sexual dysfunctions: (a) sexual phobia/aversion, (b) sexual dissatisfaction, (c) impaired sexual motivation, (d) impaired sexual arousal, (e) impaired orgasm, (f) dyspareunia, and (g) vaginismus.

The causes of these dysfunctions are categorized as (a) organic factors, (b) mood disturbances, (c) interpersonal problems, and (e) sexual stresses.

The sexual functioning of victims is assessed by (a) medical examination, (b) interviews, (c) Sexual History Form, (d) Index of Sexual Satisfaction, (e) Sexual Arousal Inventory, (f) Sexual Relationship Questionnaires, (g) reconstructive techniques, (h) confrontation, (i) recording by clients, (j) Target Complaint Scales, and (k) card sorts.

Any organic factors that may be contributing to sexual dysfunction require appropriate medical or surgical interventions. Mood disturbances and interpersonal problems are treated according to Parts 3 and 4 of the manual respectively. Sexual stresses are addressed with cognitive restructuring and training in coping skills including (a) relaxation, (b) thought and image stopping, (c) coping plans, (d) guided self dialogue, (e) imagery rehearsal, (f) roleplaying, and in vivo exposure.

The sexual dysfunctions and the assessment and treatment procedures that are summarized above are exemplified in three case studies.

Part 8. Stress Disorders

The nature and prevalence among victims of the following stress disorders are discussed: (a) Anxiety disorders, (b) sleep disorders, (c) obsessive-compulsive disorders, (d)

dissociative disorders, and (e) post-traumatic stress disorder. Each of these categories is illustrated with case material.

Part 9. Therapy With a Male Partner Who Was Sexually Victimized

The sexual abuse of boys is reviewed in the section on male victims in the recommendations for further research below. The U. of M. program was restricted to female victims but the male partner of one of these women disclosed his own sexual abuse to their therapist who treated him outside the research series but using a similar approach. This seemed to be a viable and effective intervention as shown in this part of the manual.

Part 10. Therapy With a Victim in a Lesbian Partnership

The available evidence is such that it is not possible to reach any reasonable conclusion on whether victims are more likely than non-victims to be homosexually oriented in adulthood.

In the interests of the homogeneity of the U. of M. series one of the selection criteria was that victims should be predominantly heterosexually oriented, but several of those accepted subsequently expressed some confusion about their orientation during therapy.

Most homosexually oriented women who sought treatment in the program were helped to obtain therapy elsewhere. Only one established lesbian couple applied and they were treated by one

of the program therapists but outside the research series. The apparently successful treatment of this couple is described in this part of the manual.

Part 11. Consumer Evaluation of Program

All those victims who did not drop out of treatment prematurely completed the Client Satisfaction Questionnaire at termination of therapy. Their responses to the questions on this instrument concerning the program as well as their additional comments are overwhelmingly positive. These comments also identify some specific beneficial aspects of the program and contain some recommendation for its extension.

Recommendations for Further Research

Male Victims

The treatment program and empirical findings described in the manual are restricted to women who were sexually abused in childhood but further investigation of their applicability to previously sexually abused men is highly desirable. Male victims of sexual abuse are relatively neglected in the professional literature and the provision of programs. One reason for this oversight may be that a major source of the current attention to child sexual abuse is the women's movement which has been especially concerned about the plight of female victims. There is also some societal reluctance to recognize abused boys as victims rather than willing participants in sex

encounters. Furthermore, the boys may be held responsible for their abuse because they did not resist physically as "a real boy would have done", or they prostituted themselves by receiving material rewards for sex, or they had identified themselves as homosexual prior to being abused (Rogers & Terry, 1984). Clearly, none of these putative reasons for blaming the victim constitute an adequate argument for lessening or removing the responsibility from the adult offender.

Prevalence. That the sexual abuse of boys is certainly not a rarity is evident from those studies reviewed in Appendix A which included data on male victimization. In Lewis's (1985) sample from the entire United States, 16% of 1,252 men reported having been sexually abused during childhood. The national population survey in Canada revealed that 12 % of 1002 males had undergone an unwanted touching of "a sex part" of their bodies and 10% had experienced an attempted or actual sexual assault. More than 80% of the male victims were aged under 18 years when they were first sexually abused. (Sexual offenses against children in Canada, 1984). Among a nationally representative sample of 970 males in Britain, 8% reported that they had been sexually abused before the age of 16 (Baker & Duncan, 1985). Thus, in terms of numbers alone there is ample justification for substantial professional attention to the problems and treatment of male victims.

Sexual acts. In the Canadian national population survey

(Sexual offenses against children in Canada, 1984) the commonest sexually abusive acts against males under 16 years were: (a) fondling/touching of the genital area (12%), (b) fondling/touching of breasts, buttocks (3%), (c) oral-genital sex (2%), (d) attempted anal penetration with penis (1%), and (e) anal penetration with penis (0.6%).

Offenders. Data from the U.S.A. (Finkelhor, 1984) and Canada (Sexual offenses against children in Canada, 1984) strongly indicates that sexual offenders against boys are overwhelmingly male rather than female. For example, in the Canadian national population survey only 3% of offenders against boys were female. The fact that most offenders against boys are men does not imply that these men are necessarily homosexual. Many are heterosexual and some are pedophiles with no interest in adult males (Newton, 1978).

The available evidence suggests that boys are more likely than girls to be sexually abused by non-family members, especially by someone who is known to the child such as a family friend, neighbor, teacher, or baby-sitter rather than a complete stranger (Baker & Duncan, 1985; Finkelhor, 1984).

Families of origin. Sexually abused boys are also more likely than sexually abused girls to come from poor and single parent families, and to be victims of physical as well as sexual abuse (Finkelhor, 1984).

While the reactions of parents to the abuse of their child

are generally similar for both male and female victims, on the basis of their clinical experience Rogers and Terry (1984) report two related reactions that are particularly common among the parents of abused boys. One of these reactions is to deny or minimize the victimization because of the parent's need to defend against their own feelings concerning homosexuality. The second reactions is a pronounced fear that the boy will grow up to be homosexually oriented as a result of the abuse experience.

Psychosocial adjustment in adulthood. The only aspects of the psychosocial adjustment in adulthood of males who were sexually abused as children that have received any attention in the literature are homosexuality, violence, and sexually abusive behavior, and these are reviewed below. Very limited experience with male victims treated outside the U. of M. program indicates that they experience many of the mood disturbances, interpersonal problems and equivalent sexual dysfunctions (e.g. Part 9 of manual) that are common among female victims in treatment. Thus more comprehensive and thorough investigation of the adjustment difficulties of male victims is called for.

Some evidence on an alleged association between child sexual abuse and later homosexuality in male college students is presented by Finkelhor (1984) who found that those who had been abused by older men were more than four times as likely to

be currently engaged in homosexual activity than those who had not been so abused, and almost half of the abused males were currently involved in homosexual activity. The association between homosexual experiences in childhood held only in respect of such experiences with much older males and not for similar experiences with peers.

Several possible reasons for an association between child sexual abuse and adult homosexuality have been suggested (Finkelhor, 1984; Rogers & Terry, 1984). Some boys might experience homosexual interest and curiosity at an early age which may render them vulnerable to exploitation by older predatory males. Boys who have been abused by an older man may label themselves as homosexual inappropriately because (a) they were attractive partners to him, (b) they did not physically resist his advances, (c) they engaged in homosexual acts with him, and (d) they experienced erotic pleasure during the encounter. If for any of these or other reasons a boy labels himself as homosexual then he may adopt this role and lifestyle, and such self-labeling may be reinforced by parents or peers who make similar misjudgments of the boy's reactions to the abuse and his sexual orientation.

Although systematic evidence is currently lacking it may be that sexually abused boys are prone to engage in violent behavior in later life and in this respect they may differ from most female victims. Several possible reasons have been

advanced for this alleged tendency towards aggressive behavior. It may be an attempt to resolve doubts and confusion about their sexual identity through overidentification with a stereotypical machismo image which serves to reassure the male about his masculinity and to convince others of this. It may counter feelings of powerlessness that were evoked during the abuse and be a means of protection against any revictimization. It may reflect a hatred of women derived from the victim's perception of his mother as unprotective and uncaring, which may also contribute to the sexually abusive behavior that is discussed next.

A number of studies have found that substantial proportions of sexual offenders against children were themselves the victims of sexual abuse in childhood. For example, 32% of 106 child molesters reported some form of early sexual trauma compared to 3% of 64 police officers (Groth & Burgess, 1979), and Langevin, Handy, Hook, Day, and Russon (1983) found that incest offenders were five times more likely to have experienced sexual abuse as children compared to non-offender controls. Such results do not of course mean that all male sexual abuse victims become sexual abusers, and at present, it is not known what proportion of victims do so or what factors influence whether this happens (Finkelhor, 1986). Sgroi (1982) comments as follows on adolescent males who are both current abusers and previous victims: "We have seen

adolescent males, who were themselves previous victims of sexual abuse by a male perpetrator, engaging their sisters and younger children, both male and female, in sexual behavior. Much of this sexual behavior appeared to be in the service of a need to control or dominate another person, rather than to satisfy a sexual need: Much of this type of sexual behavior was abusive in fact as well as in name; force or intimidation was used with agemates as well as with younger children and trauma to the victim would often result" (p. 31). The need to control or dominate another person mentioned in this quotation may sometimes represent an attempt by the offender to master the helplessness and hurt of his own victimization by re-enacting similar experiences with himself in the position of power, although no doubt many other factors also contribute to the sexually abusive behavior of men who were themselves abused in childhood.

Treatment. Despite the paucity and inadequacy of the evidence that is currently available it seems clear that some men experience psychosocial problems that are related to child sexual abuse and associated family experiences. There does not appear to be any intervention programs for this client group reported in the literature and this is a very significant gap, especially in view of the alleged propensity of some of these men to engage in violent or sexually abusive behavior. The effective treatment of these and other problems associated with

child sexual abuse in males might prevent the victimization of other people and reduce the transmission of sexual abuse across generations.

It seems likely that some of the procedures used in the U. of M. program with previously sexually abused women might be helpful with male victims. For example, feelings of guilt and low self esteem might be alleviated by the cognitive restructuring of distorted beliefs concerning responsibility for the abuse or sexual orientation, and violent behavior might be mitigated by procedures such as anger control and assertiveness training. Thus, it seems worthwhile to develop and evaluate appropriate aspects of the U. of M. program with men who were sexually abused in childhood and who present with problems associated with this earlier experience.

Partners

A number of problems relating to the victims' partners were encountered in the U. of M. program.

Discord between victim and partner occurred in all couples, often arising from (a) the exploitation, oppression, and sometimes physical abuse of the victim by the partner, (b) the overdependence of the partner on the victim, and (c) the dissatisfaction and distress of the partner concerning certain aspects of the relationship.

This last source of discord sometimes stemmed from the implications of the victim's problems for her partner; for

example, her mistrust of all men, or her difficulties in participating and responding in a sexual relationship. Partners also often found it hard to understand, accept, and adapt to certain changes in their spouse during treatment, such as enhanced self-esteem, desire for growth as an individual, reallocation of roles in the relationship, or increased assertiveness. For these and other reasons some partners felt (a) that they were vicarious victims, (b) deprived and confused in their relationship with the victim, (c) angry and hostile toward the offender, and (d) negative about themselves and depressed in mood.

Another problematic area was the role of the partner in therapy. Some victims did not want their partner to participate, and some partners refused to do so, in either case it was difficult to deal satisfactorily with interpersonal and sexual problems that involved both spouses. Even when partners did attend sessions, typically they perceived this as helping the victim to resolve her problems - a role they had often fulfilled over many years - and were very resistant to entering the client role themselves despite the relationship and individual problems they might be experiencing. Finally, because the victim had presented as the identified client with a wide range of very distressing problems requiring prompt and intensive intervention, she had been the primary focus of therapy at least in its earlier stages. This made it difficult

for the therapist to give adequate attention to the partner, who tended to think also that it would be inappropriate, unfair, and therapeutically damaging to expect the victim and therapist to yield therapeutic time to his concerns. Some useful light is cast on this issue by the comments of the partner quoted in Part 10 of the manual.

It is partly as a result of this partner's experiences quite early during the U. of M. program that regular individual sessions and a situation/transition group for partners were added to the other interventions with couples that are discussed in part 4 of the manual. This range of interventions and the many other complex partner-related issues reviewed in this section call for more extensive and rigorous investigation.

Sequencing Target Problems

In the U. of M. program the most usual order of treatment for the major target problems was mood disturbances, interpersonal problems, and sexual dysfunctions, although this was subject to the guidelines listed in part 2 of the manual and other high priority problems sometimes required previous or concurrent attention. There are several reasons for sequencing the target problems in this way. Prima facie, it seems appropriate to correct the self-blaming and self-denigratory beliefs that are rooted in the past sexual abuse in order to relieve the victim of this burden before she attempts to

resolve her current interpersonal and/or sexual problems. There are indications also that the successful treatment of sexual dysfunction usually requires the prior alleviation of mood disturbances and marital discord (part 7 of manual). Finally, treatment focussed upon mood disturbances is not infrequently accompanied by the resolution of marital and/or sexual problems so that further specific marital or sex therapy is not necessary (part 3 of manual). Thus, the order in which the target problems were most usually treated in the U. of M. program seems quite appropriate but more systematic exploration of the feasibility and efficacy of this and alternative sequences would be worthwhile, in particular in order to determine whether the duration of therapy could be reduced without detriment to its effectiveness.

Group Treatment

The primary formats in the U. of M. program were individual or couple therapy although some victims participated also in an assertiveness training group. These participants subsequently advocated the inclusion of some form of group experience in the program, and the potential advantages of this are noted in part 2 of the manual. Thus, it seems desirable to consider the provision of group therapy in programs for victims.

Among the many treatment planning issues that this raises is whether such therapy should be an alternative or an adjunct

to the individual or couple formats. Some victims are unsuitable or unwilling to attend and participate in a group, and there may not be enough victims available to institute a group at a particular point in time, therefore it is important to keep open the options of individual or couple therapy for those who need or prefer them. There is also the question of whether some victims can obtain sufficient attention and support to meet their individual needs in a group context (e.g. Herman & Schatzow, 1984). On the other hand, to the extent that group treatment can replace individual or couple therapy then this may conserve scarce professional resources. In conclusion, comprehensive and rigorous inquiries are needed into how group treatment can best be provided in programs for previously sexually abused women and their partners.

Gender of Therapist

The individual and couple therapy in the U. of M. program was in most cases conducted by a female therapist, consequently the only information available on the influence of the therapist's gender comes from the participants in the assertiveness group who found the presence of the male co-therapist to be helpful to them. Some possible advantages and disadvantages of female and male therapists respectively are reviewed in part 2 of the manual and it is concluded as working hypotheses (a) that the balance is generally in favour of females, although (b) the involvement of a male is desirable

when the victim is experiencing difficulties in her relations with men, and (c) the provision of male-female co-therapy teams is worth considering, especially when the victim's partner is participating in therapy. These and related hypotheses concerning the gender of the therapist(s) merit systematic investigation, at least because the available pool of therapists is larger if it does not need to be restricted to females.

Conclusion

It seems reasonable to say that the treatment package used with mood disturbances in the U. of M. program has been shown to be feasible, acceptable, and effective for many victims, although it could usefully be replicated in other clinical settings. The packages used with interpersonal problems and sexual dysfunctions, while apparently promising, are not yet as well established and still require further development and evaluation.

Once a package is shown to be an effective treatment for specific problems in particular clients then several other clinical research issues arise including:

(a) What are the necessary and sufficient components in the package that contribute to its efficacy? Once these crucial ingredients are identified then the package can be refined by optimising these ingredients and eliminating those that are unnecessary.

(b) What is the effect on the efficacy of the package of varying certain parameters such as its duration or the spacing of sessions? This information can be used to increase the efficiency of delivery.

(c) What is the effect on the efficacy of the package of varying the clients or therapists? The extensions to male victims or to groups of victims, and the inclusion of male therapists, that are discussed above are examples of research topics in this category.

(d) How effective is the package compared to other treatment approaches? Only when a package has been shown to be effective is it worthwhile mounting comparative studies that usually require considerable resources.

Thus, like all research, the U. of M. program is just one step in an ongoing process of inquiry that progressively will improve the quality of help that can be offered to the many troubled victims of child sexual abuse.

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APPENDIX A

Extract from Jehu, D.

Therapy with women who were sexually abused in childhood

Until quite recently the sexual abuse of children was generally regarded as a rare occurrence and reports of it happening tended to be attributed to Oedipal fantasies (Masson, 1984; Rush, 1980). We know now that it is not uncommon and that many reports are only too real rather than imagined. The purpose of this chapter is not to review the evidence on the prevalence of sexual abuse in detail (see Peters, Wyatt, & Finkelhor, 1986; Russell, 1986) but to present some of the best established findings on its occurrence among females in the United States of America, Canada, and Great Britain, as contextual background for later discussion of the nature of sexual abuse, the psychosocial problems that are sometimes associated with it, and the treatment of these problems in adult women.

Prevalence in the U.S.A.

The only study based on a random sample of the population of the entire United States was conducted by Lewis (1985). The knowledge, attitudes, and personal experiences of 1,374 females concerning child sexual abuse were surveyed in a telephone interview lasting half an hour. Some form of sexual abuse during childhood was reported by 27% of these subjects.

Two other studies have been conducted with random samples drawn from more restricted populations. In San Francisco, Russell (1983, 1986) obtained a samples of 930 women which

represented a 50% response rate. A face to face interview lasting an average of 1 hour 20 minutes was conducted with each respondent. In Los Angeles County, Wyatt (1985) obtained a sample of 248 women which represented a response rate of 55%. Each respondent was interviewed on a face to face basis for between 3 to 8 hours.

In Russell's study "extrafamilial child sexual abuse was defined as one or more unwanted sexual experiences with persons unrelated by blood or marriage, ranging from petting (touching of breasts or genitals or attempts at such touching) to rape, before the victim turned 14 years, and completed or attempted forcible rape experiences from the ages 14 to 17 years (inclusive) ... intrafamilial child sexual abuse was defined as any kind of exploitive sexual contact that occurred between relatives, no matter how distant the relationship, before the victim turned 18 years old. Experiences involving sexual contact with a relative that were wanted and with a peer were regarded as nonexploitive, for example, sex play between cousins or siblings of approximately the same ages. An age difference of less than five years was the criterion for a peer relationship." (1983, pp. 135-136). Originally, Wyatt used a slightly different definition of extrafamilial abuse but she has recalculated her prevalence rates according to Russell's definition and has reported the rates for both studies (Wyatt & Peters, 1986a) as shown in Table 1.1.

Thus, in summary, the prevalence rates for all forms of child sexual abuse among females in the United States are variously reported as 54% by Russell, 53% by Wyatt and Peters, and 27% by Lewis. Some possible reasons for this variation in rates are discussed in the conclusion to this chapter but it seems clear that sexual abuse is experienced by a substantial proportion of American women.

Table 1.1

Prevalence of Child Sexual Abuse in San Francisco (Russell, 1983) and Los Angeles (Wyatt and Peters, 1986a)

	San Francisco		Los Angeles	
	n	%	n	%
Contact Abuse				
Intrafamilial:				
Up to age 13	109	12	42	17
Up to age 17	152	16	51	21
Extrafamilial:				
Up to age 13	189	20	57	23
Up to age 17	290	31	69	29
Intrafamilial and/or extrafamilial:				
Up to age 13	258	28	89	36
Up to age 17	357	38	104	42
Contact and Noncontact Abuse Combined				
Up to age 13	450	48	117	47
Up to age 17	594	54	131	53

Note. The data in columns 1 to 4 are from "Issues in the Definition of Child Sexual Abuse in Prevalence Research" by

G.E. Wyatt and S.D. Peters, 1986 Child Abuse and Neglect, 10, p. 237. Copyright 1986 by the Pergamon Press. Adapted by permission.

Prevalence in Canada

A random sample of 1006 women drawn from the national population of Canada completed a questionnaire that was delivered and collected by a member of the survey staff. These respondents constituted a response rate of approximately 94%. An unwanted touching of a "sex part" of their body was reported by 23% of the respondents and 22% said that someone had tried to have sex with them when they did not want this or that they had been sexually attacked. The unwanted sexual acts in both these categories occurred in approximately two-thirds of cases when the victims were aged under 18 years, and in one-third when they were aged under 14 years (Sexual Offences Against in Canada, 1984). Thus, sexual abuse involving physical contact was experienced during childhood by a substantial proportion of Canadian women.

Prevalence in Great Britain

In Britain, Baker and Duncan (1985) studied a nationally representative sample of 1049 women each of whom was interviewed on a face to face basis. They were asked if they had ever been sexually abused according to the following definition: "A child (anyone under 16 years) is sexually abused

when another person, who is sexually mature, involves the child in any activity which the other person expects to lead to their sexual arousal. This might involve intercourse, touching, exposure of the genital organs, showing pornographic material or talking about sexual things in an erotic way" (Baker & Duncan, 1985, p. 458). An affirmative reply was given by 12% of the respondents and another 12% refused to answer the question. Among those who reported sexual abuse this had involved physical contact in 40% of cases, and it was intrafamilial in 14% of cases. These prevalence rates appear to be generally lower than those reported in the United States and Canada but even so child sexual abuse is clearly not a rarity in Britain.

Conclusion

The variations in reported prevalence rates within and across national boundaries may be due to any combination of differences in definition, sampling, and methodology (Peters, Wyatt, & Finkelhor, 1986; Wyatt and Peters, 1986a, 1986b).

Among the differences in the definition of child sexual abuse in various studies are the upper age limit adopted for victims of such abuse, the inclusion or exclusion of abuse that does not involve physical contact such as encounters with exhibitionists or sexual solicitations, and the criteria for defining a sexual encounter as abusive such as the extent to

which it is unwanted or coercive and the required age discrepancy between victim and offender.

Differences in the characteristics of the subject samples in various studies may contribute to variations in the prevalence rates that are reported. Relevant sample characteristics might include the age range of the subjects and their educational level, socio-economic status, ethnic membership, and geographical location.

Finally, variations in prevalence rates may be influenced by differences in the methodology utilized in various studies. These differences might involve the techniques used to draw the subject samples, the response rates obtained for participation in the study, the type and number of questions about sexual abuse, or the format in which these questions are administered such as in a questionnaire to be completed by the subject or by means of a face to face interview or telephone inquiry.

Despite the variations in reported prevalence rates for any of the reasons just outlined it is evident that child sexual abuse is common among females in the general populations of several countries. The upshot of this for clinicians is that they are virtually certain to encounter women who have had such experiences among their clients. Moreover, as discussed in later chapters, previously sexually abused women tend to be overrepresented in many client groups and their past abuse experiences may well be contributing to their current

psychosocial problems and therefore need to be addressed in therapeutic attempts to resolve these problems.

APPENDIX B

Extract from Jehu, D.

Therapy with women who were sexually abused in childhood

In parts 2, 3, and 4 of this book very high prevalence rates for various mood disturbances, interpersonal problems, and sexual dysfunctions are reported for the previously sexually abused women in the U. of M. series and other clinical samples.

Clearly, such women who enter therapy are selectively biased towards pathology and their prevalence rates cannot be generalized to other victims who have not sought treatment. At present there is very little evidence concerning the proportion of sexual abuse victims who experience psychosocial problems in adult life. The survey of the British general population conducted by Baker and Duncan (1985) and described in chapter 1 is one of the most informative sources to date. Among 119 female victims there were 61 (57%) who considered their abuse to have been unpleasant and harmful at the time but to have had no long-lasting effects, 16 (13%) considered it to have been permanently damaging with long term effects, 40 (34%) considered it to have had no effects at all, and 2 (2%) considered it to have improved the quality of their lives. Perceived permanent damage appeared to be associated particularly with intrafamilial abuse of a repeated nature, which commenced before the age of 10 years. Similarly, Russell (1986) has reported on 187 experiences of intrafamilial sexual abuse that were described by 152 victims drawn from her random sample of the population in San Francisco. Thirty three

percent of these experiences were described as extremely upsetting, 20% as very upsetting, 27% as somewhat upsetting, 12% as not very upsetting, and 9% as not at all upsetting. Twenty five percent of the experiences were described as having had great long-term effects, 26% to have had some effect, 27% to have had little effect, and 22% to have had no long term effect. Thus, the sexual abuse was considered to have been permanently damaging by 13% of the victims in the Baker and Duncan study, and 25% of the experiences in the Russell study were described as having had great long-term effects. Clearly, more rigorously established prevalence rates for more precisely defined problems are needed from representative samples of previously sexually abused women.

The U. of M. project is primarily a study of the treatment rather than the epidemiology of problems associated with child sexual abuse. Consequently, the project did not include comparison groups of women who had not been abused and who were either (a) in therapy, or (b) in the general population. Thus, it is not possible to be certain how the prevalence rates for various psychosocial problems among the victims in the U. of M. series compare to those for non-abused women in other clinical or non-clinical groups. Such comparisons between abused and non-abused samples have been made in some other investigations which are cited in parts 2, 3, and 4, and they are a necessary basis for ascertaining the extent to which sexual abuse is a

pathogenic influence over and above other events in the lives of victims.

Even when sexual abuse does appear to be associated with increased pathology in adulthood it is difficult to distinguish the extent to which this is attributable to the sexual acts per se or to other circumstances surrounding the abuse such as the negative parental reactions to disclosure discussed in chapter 2, and the adverse family backgrounds discussed in chapter 3.

In summary, very high prevalence rates for a range of psychosocial problems are reported in the U. of M. study, but these rates cannot be generalized to victims who have not entered therapy, and it is not certain how they compare to the rates for similar problems among non-abused women. Furthermore, if these problems are more common in groups of sexually abused women it is not clear to what extent this is due to the sexual acts involved or to other circumstances surrounding the abuse. Despite these limitations the fact remains that the women in the U. of M. series were experiencing many problems ...

APPENDIX C

Presentations to Conferences and Workshops

1986	April	Student Counselling Service University of Manitoba Winnipeg, MB
1985	May	Child Care & Development Dept. Department of Education Province of Manitoba Winnipeg, MB
	April	Red River Community College School of Nursing Winnipeg, MB
	March	Faculty of Human Ecology Department of Family Studies University of Manitoba Winnipeg, MB
	February	Counselling the Sexual Abuse Survivor Conference sponsored by Klinic Community Services, Inc. Winnipeg, MB
	January	Interfaith Pastoral Institute University of Winnipeg Winnipeg, MB
1984	November	Elizabeth Fry Society of Manitoba Winnipeg, MB
	September	5th International Congress on Child Abuse Montreal, PQ
	June	CBC Winnipeg - "24 Hours" Winnipeg, MB
	April	Winnipeg Education Centre University of Manitoba - extension program Winnipeg, MB
	April	Annual Conference of the Manitoba Behavior Modification Assn. Winnipeg, MB
	March	Native Child Welfare Urban Coalition Winnipeg, MB

1984	February	CBC TV Winnipeg - "Take 30" Winnipeg, MB
	February	Institute for the Advanced Study of Human Sexuality San Francisco, CA
	January	Children's Aid Society of Winnipeg Child Abuse Unit Winnipeg, MB
1983	December	Department of Psychology University of Winnipeg and Manitoba Behavior Modification Association Winnipeg, MB
	November	St. Boniface Hospital Day Conference on Gynecology Winnipeg, MB
	November	Red River Community College Child Care Service Program Winnipeg, MB
	November	Focus on Women Conference Winnipeg, MB

Canada